

STATE OF MICHIGAN
DEPARTMENT OF LABOR & ECONOMIC GROWTH
OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX

Petitioner

File No. 84608-001-SF

v

Blue Cross Blue Shield of Michigan
Respondent

_____/

**Issued and entered
this 18th day of December 2007
by Ken Ross
Acting Commissioner**

ORDER

I
PROCEDURAL BACKGROUND

On August 21, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under public Act No. 495 of 2006, MCL 550.1951 *et seq.* The Commissioner reviewed the request and accepted it for external review on August 28, 2007.

Section 2(2) of Act 495, MCL 550.1952(2), requires the Commissioner to conduct this external review as though the Petitioner were a covered person under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901 *et seq.*

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on September 7, 2007.

The issue in this external review can be decided by a contractual analysis. The Petitioner is enrolled for health coverage with BCBSM through the XXXXX PPO health plan (the plan), a self-funded group that provides health care benefits to XXXXX employees and their eligible dependents. BCBSM's *Your Benefits Guide* (the benefit guide) describes the Petitioner's coverage and certain restrictions and limitations on that coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II FACTUAL BACKGROUND

The Petitioner received services from XXXXX from February 2 through March 9, 2007. During that time XXXXX was no longer a participating provider so BCBSM paid its approved amount for the services directly to the Petitioner.

Based on the explanation of benefit statements for the period February 2 through March 9, 2007, this table shows the amounts paid to the Petitioner by BCBSM for the services she received:

Date of Service	CPT Code	Provider Charge	BCBSM Approved Amount for Service	BCBSM Paid to Petitioner	Petitioner's Out-of-Pocket Expense
2/2/07	58340	\$ 235.00	\$ 195.53	\$ 195.53	\$ 39.47
2/2/07	99211	50.00	-0-	-0-	50.00
3/3/07	76857	\$ 144.00	\$ 108.16	\$ 108.16	\$ 35.84
3/3/07	82670	78.00	42.94	42.94	35.06
3/6/07	76857	149.00	108.16	108.16	40.84
3/6/07	82670	81.00	42.94	42.94	38.06
3/8/07	76857	149.00	108.16	108.16	40.84
3/8/07	82670	81.00	42.94	42.94	38.06
3/9/07	76857	144.00	108.16	108.16	35.84
3/9/07	82670	78.00	42.94	42.94	35.06
Total				\$ 799.93	

BCBSM subsequently requested a refund of those payments, saying they were paid in error because the services are not covered under the plan.

The Petitioner appealed BCBSM's request for a refund of its payments for the care provided by XXXXX. BCBSM held a managerial-level conference on July 16, 2007, and issued a final adverse determination dated July 26, 2007, affirming its decision to seek a refund.

III ISSUE

Is BCBSM entitled to a refund of the amount it paid for the Petitioner's care at XXXXX from February 2 through March 9, 2007?

IV ANALYSIS

Petitioner's Argument

According to the Petitioner, in the summer of 2006 she carefully reviewed the XXXXX PPO plan before deciding to select it for her health care coverage. She believed that the plan was the most comprehensive coverage choice available to her and would meet her health care needs. In addition, XXXXX participated with the plan at that time.

The Petitioner says that BCBSM is denying payment for simple blood work and ultrasounds she received from XXXXX. She says the information she received as a plan member does not indicate that these services are not covered, and she points out that the benefit guide shows that tests and laboratory work are a covered benefit. She asks that BCBSM be prohibited from recovering the money it paid for these services.

Once the Petitioner received BCBSM's May 29, 2007, letter requesting the refund, she says she once again reviewed the benefit guide and could not find any mention that services are not covered when performed at a reproductive clinic.

The Petitioner believes that her care provided by XXXXX is a covered benefit and BCBSM is not entitled to a refund.

BCBSM's Argument

BCBSM says the Petitioner was receiving infertility treatment. It points out that the CPT codes for the services provided by XXXXX were 58340 (a minor surgical procedure that involves

catheterization and the introduction of material for saline infusing sonohysterography or hysterosalpingography); 82670 (laboratory test for estradiol); and 76857 (an ultrasound). The diagnostic code included on the claims forms submitted by the provider for all of these services was 682.9: “infertility, female, unspecified.”

On page 66 of the benefit guide, in the section entitled “What’s Not Covered under the State Health Plan PPO,” is the following exclusion:

- Services that are not included in your plan coverage documents.

BCBSM says the plan’s coverage documents do not include services related to the treatment of infertility and therefore they are not covered. Since the claims for the care provided by XXXXX were submitted with a diagnosis code of infertility, BCBSM says the services are infertility treatment and are not a covered benefit.

BCBSM acknowledges that it initially paid for this care in error, but says it soon noticed the mistake and requested reimbursement for payments. BCBSM argues that it is entitled to a refund from the Petitioner.

Commissioner’s Review

The only issue to be resolved in this case is whether BCBSM may recover payments made to the Petitioner for services provided by XXXXX. To answer this question, the Commissioner must discuss the Petitioner’s coverage under the plan, but the Commissioner makes no dispositive finding on whether the plan generally covers infertility treatment.

BCBSM says that given that the XXXXX PPO plan is a self-funded arrangement, there is no certificate of coverage as there would be for underwritten coverage. BCBSM says that the benefit guide is a summary description of the Petitioner’s benefits and not a contract. BCBSM further says that other applicable “coverage documents” set forth the actual terms of the Petitioner’s coverage, and that since infertility treatment is not listed as a covered service in the coverage documents, it is excluded from coverage.

The Commissioner recognizes that self-funded plans like the XXXXX PPO plan have broad discretion to define the benefits provided to their enrollees. In this case, those benefits have been described in considerable detail in the 90-page benefit guide. The benefit guide says it is a “summary description of benefits” and that the terms and conditions contained in the coverage documents prevail. However, the Commissioner finds that the benefit guide is a sufficiently comprehensive document to reasonably serve as the source for the Petitioner’s health care benefits for this review under PRIRA, particularly since BCBSM says that the underlying coverage documents (which were not submitted by BCBSM and are not part of the record) do not contain any reference to infertility benefits.

The benefit guide says that it excludes “services that are not included in your plan coverage documents,” and it is true that infertility is not included in the benefit guide. However, infertility is a condition, not a service. The services the Petitioner received (diagnostic and laboratory services) *are* included in the benefit guide. BCBSM has focused not on the covered services but on the diagnosis. BCBSM is requesting reimbursement for payments made for services that would otherwise be covered except for the fact that the claims included a diagnosis code of infertility. Nowhere in the benefit guide does it say that covered services (like the laboratory tests and ultrasound that the Petitioner received) may be denied on the basis of a specific diagnosis.

The benefit guide, under “Physician and Other Professional Services,” says that “surgical services” and “diagnostic and radiation services” (e.g., ultrasound and laboratory tests) are covered benefits. These are kinds of services the Petitioner received from XXXXX. The Commissioner also notes that while the benefit guide places some limits on surgical services (e.g., no cosmetic surgery) and on diagnostic and radiation services (e.g., one mammogram per year), there is nothing that says these services are not available for infertility treatment.

The medical necessity of the services related to the diagnosis of infertility is also not at issue here. The benefit guide specifically says on page 29:

Medical necessity for physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

- The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the members or physicians.
- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care. [Underlining added]

Nothing in the record contradicts a finding that the services the petitioner received from XXXXX were medically necessary for her condition (infertility) under this definition.

The Commissioner finds that the coverage information provided to the Petitioner establishes that the services she received were covered benefits. Based on the particular facts of this case, the Commissioner concludes that BCBSM correctly reimbursed the Petitioner \$799.93* for medically necessary services and is not entitled to recoup that amount from the Petitioner. However, nothing in this Order should be construed as establishing the right of the Petitioner to any infertility services.

V ORDER

Respondent BCBSM's final adverse determination of July 26, 2007, is reversed. BCBSM is not entitled to request a refund from the Petitioner of \$799.93 for the services provided by XXXXX from February 2, 2007, through March 9, 2007.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order

* This total differs slightly from the \$789.70 BCBSM said it was seeking to recover in its May 29, 2007, letter to the Petitioner.

in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, Michigan 48909-7720.